Kentucky Employees' Health Plan
Department of Employee Insurance
kehp.ky.gov ● 1.888.581.8834

2016 AFFORDABLE CARE ACT (ACA) HEALTH INSURANCE ENROLLMENT APPLICATION

Section 1: To Be Completed by IC/HRG

KHRIS Personnel Number	Organizational Unit #	Company Name	Company #	Home County Code

Reason for Application ❑ New ACA ❑ Term ACA	**Coverage Effective Date**	**Coverage Term Date**	Cost Center #

Section 2: Demographic Information

Employee's SSN	Name (Last, First, MI)	Date of Birth

Street Address	Primary Phone Number	Work Email Address

City, State, ZIP	Home County	Secondary Phone Number	Home Email Address

Sex Male ❑ Female ❑	Married Yes ❑ No ❑	Within the past 6 months, have you, or a spouse or dependent(s) age 18 and over, to be covered under your insurance plan, used tobacco regularly? Yes ❑ No ❑

Section 3: Spouse/Dependent Information *Complete Section 3 only if you are electing parent plus, couple or family coverage*

Spouse's Information

Social Security Number	Name (Last, First, MI)	Date of Birth	Sex Male ❑ Female ❑

Cross-Reference Payment Option ONLY (LRP, JRP not eligible)

1. Do you and your spouse utilize the cross-reference payment option? [two employees, married with child(ren)]? Yes ❑
2. Within the past 6 months, have you, the spouse, used tobacco regularly? Yes ❑ No ❑

3. Date of Hire/Retirement	4. Organizational Unit #	5. Company #

Dependent(s) Information – *If you need additional room for dependents, add them to another page and include as part of the application.*

Child 1 Social Security Number	Name (Last, First, MI)	Date of Birth	❑Male ❑Female ❑Disabled Dep.
Child 2 Social Security Number	Name (Last, First, MI)	Date of Birth	❑Male ❑Female ❑Disabled Dep.
Child 3 Social Security Number	Name (Last, First, MI)	Date of Birth	❑Male ❑Female ❑Disabled Dep.

Section 4: Plan Options

❑ LivingWell CDHP ⟶ ❑ I AGREE to the LivingWell Promise
❑ LivingWell PPO ⟶ ❑ I AGREE to the LivingWell Promise

If you do NOT AGREE to the LivingWell Promise you must select a Standard plan option below

❑ Standard PPO
❑ Standard CDHP

Section 5: Coverage Levels

❑ Single (self only)	❑ Parent Plus (self and child(ren))	❑ Couple (self and spouse)	❑ Family (self, spouse and child(ren))

Section 6: Waiving Health Insurance (no health insurance)

If you waive your health insurance AND you are eligible and can declare that you have other group health plan coverage, you will receive $175 per month up to $2,100 annually into a Health Reimbursement Arrangement (HRA).This is employer-funded; you do not contribute any money.

❑ Waiver (General Purpose) HRA-with $ *By choosing a Waiver HRA and checking this box, I declare that I have other group health plan coverage that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through kynect or governmental plans such as TRICARE, Medicare, or Medicaid. A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services.*

❑ Waiver Dental/Vision ONLY HRA-with $ *You may choose this option if you are not eligible for the Waiver HRA. May be used for dental and vision only.*

❑ No HRA-without $

Plan Year 2016

Employee's SSN

Employee's Name

TOBACCO USE DECLARATION

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As a part of the KEHP wellness program, KEHP provides a monthly discount in premium contribution rates for non-tobacco users. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

TOBACCO USE INFORMATION
Check the applicable box below: Within the past six months, have you, or a spouse or dependent to be covered under your insurance plan, used tobacco regularly? **Yes** ☐ **No** ☐
NOTE: Regularly means tobacco has been used four or more times per week on average excluding religious or ceremonial uses.
NOTE: "Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the frequency or method of use.
NOTE: "Dependent" means, for the purpose of the Tobacco Use Declaration, only those dependents who are 18 years of age or older.

By submitting this form, I certify the following:

1. I have truthfully checked the Yes or No box above that accurately reflects the use of tobacco products in the past six months regarding myself and persons to be covered as a spouse or dependent under my insurance plan.
2. I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2016 if I answered "Yes" to the question above.
3. I understand that it is my responsibility to notify KEHP of any changes in my tobacco-use or that of my spouse or a dependent covered under my insurance plan, including notification to KEHP if all tobacco users become ineligible for coverage or are otherwise terminated during the plan year. Notification shall be made by completing a Tobacco Use Change Form.
4. I understand that if I or a spouse or dependent to be covered under my insurance plan currently use tobacco products and stop using tobacco products during the plan year, I will be eligible for the discount non-tobacco premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form certifying that neither I nor my spouse/dependent(s) regularly used tobacco products during the six months prior to completion of the Tobacco Use Change Form.
5. I understand that if I answered "No" to the question above and either I or a spouse or dependent covered under my insurance plan become a regular tobacco user at any time, I must notify KEHP and my contribution rates will be adjusted to the tobacco-user premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form.
6. I understand that this Tobacco Use Declaration is a part of my KEHP application for health insurance coverage. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information, or who conceals, for the purpose of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
7. I understand that if I fail to complete this Declaration truthfully, KEHP may adjust my contribution rates retroactively to apply the applicable higher tobacco-user premium contribution rates. Upon written notification, I will pay to KEHP the difference between the tobacco-user and the non-tobacco user premium contribution rates for the period for which I falsely certified eligibility for the non-tobacco user premium contribution rates.
8. The KEHP offers monthly discounted premium contribution rates to non-tobacco users as a part of its wellness program. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Review the Authorization and Certification information below.

Authorization and Certification for elections made by the planholder for health insurance coverage through the Kentucky Employees' Health Plan (KEHP or Plan), administered by the Department of Employee Insurance (DEI). For the purposes of this Authorization and Certification, FSA refers to a Healthcare Flexible Spending Account and a Dependent Care Flexible Spending Account, collectively. A Healthcare Flexible Spending Account will be referred to as a Healthcare FSA. A Dependent Care Flexible Spending Account will be referred to as a Dependent Care FSA.

My signature on this application for health insurance creates a legal and binding contract. By affixing my signature, I understand and agree that:

- If I am electing a KEHP plan option or enrolling in an FSA during open enrollment, the plan and FSA will be effective January 1 of the following plan year. If I am a new employee or a newly eligible employee electing a KEHP plan option or enrolling in an FSA outside of open enrollment, the plan and/or FSA will be effective the first day of the second month after a new employee or newly eligible employee is eligible to enroll in the health plan or an FSA.
- I have read and understand the 2016 KEHP Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) or Medical Benefit Booklets (MBB) and the Summary of Benefits and Coverage (SBC).

- All KEHP benefits for my eligible dependents and me will be provided in accordance with the limitations in the SPDs, MBBs, BSG, and SBCs. I will abide by all terms and conditions governing participation in an FSA and as set forth in the SPD, and by all terms and conditions governing membership and receipt of services from the plan in which I have enrolled and as set forth in the SPD and MBB. In the event of a conflict between the terms of coverage stated in the SPDs, the MBBs, the BSG, and the SBCs, the terms of coverage stated in the SPDs and/or MBBs will govern.
- KEHP uses third parties, including Anthem, CVS Caremark, and WageWorks to provide certain administrative functions. KEHP may communicate with me directly or through these third parties about my coverage, my benefits, or health-related products or services provided by or included in KEHP's plan of benefits.
- If my spouse and I elect the cross-reference payment option, we are planholders with family coverage, and upon a loss of eligibility by either spouse, the remaining planholder will default to a parent plus coverage level. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.
- I certify that each enrolled dependent meets KEHP's dependent eligibility requirements as set forth in the SPD and/or the MBB. DEI may require supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan.
- The elections indicated by this application may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- Enrollment in an FSA is voluntary. I authorize my employer to deduct from my earnings the amount required to cover my employee contribution to the FSA I have selected, including any arrears I may owe. I authorize payment of my employee contributions to be made on a pre-tax basis.
- I authorize my employer to deduct from my earnings the amount required to cover my employee share of the premium contribution for the plan option I have selected, including any arrears I may owe. I authorize payment of my employee premium contributions to be made on a pre-tax basis unless I sign a Post-Tax Request Form.
- Any payment submitted to KEHP that I intend to be used to fund my FSA and any premium payment submitted to KEHP that I intend to be used to pay for my health insurance premium contributions may first be used to pay other priority debts that may be due and owing such as taxes and child support.
- If I choose a Dependent Care FSA, I am eligible to seek reimbursement, as authorized by 26 U.S.C. Sections 21 and 129, for dependent care expenses. The Dependent Care FSA may only reimburse eligible dependent care expenses that are incurred during the applicable coverage period.
- Any unused amount remaining in my Healthcare FSA at the end of the calendar year will be carried forward to the next calendar year, up to a maximum carry over amount of $500.00.
- WageWorks will administer FSAs and HRAs for the 2016 plan year and will issue to me a WageWorks Healthcare Card for the payment of Healthcare FSA and HRA expenses. My WageWorks Healthcare Card will be suspended if the required claim verification is not sent to WageWorks within ninety (90) days after the card swipe. I agree to follow all rules and guidelines established by the Plan concerning the WageWorks Healthcare Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from my paycheck, and offset my Healthcare FSA or HRA if I fail to properly verify a claim.
- If I elect to waive KEHP health insurance coverage, with or without a Waiver Health Reimbursement Arrangement (HRA), I am doing so voluntarily. If your employer participates in the Waiver HRA program, there are two options available: the Waiver General Purpose HRA and the Waiver Dental/Vision Only HRA. I understand that I will be eligible for the Waiver General Purpose HRA only if I have other group health plan coverage.
- If I elect a Waiver General Purpose HRA, I declare that I am enrolled in another group health plan that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through kynect or governmental plans such as TRICARE, Medicare, or Medicaid. A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services.
- If I elect a Waiver General Purpose HRA and I cease to be covered under another group health plan that provides minimum value, I will notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated and I may elect a KEHP health insurance plan option or the Waiver Dental/Vision Only HRA. I am permitted to permanently opt out of and waive future reimbursements from the Waiver General Purpose HRA at least annually at open enrollment.
- Any funds remaining in a Waiver HRA after termination may be used to reimburse the employee for eligible expenses incurred prior to termination of the Waiver HRA. Upon termination of employment, the remaining amounts in a Waiver HRA are forfeited except that I may be reimbursed for any eligible medical expenses incurred prior to the last day of the last pay period worked, provided that I file a claim by March 31 following the close of the plan year in which the expense was incurred.
- KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through my employer, I am not eligible for a health insurance premium tax credit if purchasing insurance through kynect. In addition, if I decline coverage for my spouse or dependent, my spouse or dependent will not be eligible for a health insurance premium tax credit if purchasing insurance through kynect.
- An HRA and/or Healthcare FSA may only reimburse me for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. The Waiver Dental/Vision Only HRA may only reimburse me for eligible dental and vision expenses. Pursuant to federal law, the cost of over-the-counter medicines (other than insulin and those prescribed by a doctor) may not be reimbursed through my HRA or Healthcare FSA.
- I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA and HRA expenses incurred during my period of coverage.
- Any unused amount remaining in my HRA at the end of the plan year may be carried forward to the next plan year provided I am eligible to elect an HRA. I must elect the same type of HRA in a subsequent plan year for the funds to carry over.

Employee's SSN

Employee's Name

- The four KEHP plan options and the Waiver General Purpose HRA must pay primary to Medicare. The Waiver Dental/Vision Only HRA pays secondary to Medicare.
- The KEHP offers discounted premium contribution rates to non-tobacco users as a part of its wellness program. If either I or a spouse or dependent to be covered under my insurance plan have used tobacco regularly within the past six months, I will not qualify for the discounted employee premium contribution rates. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees/retirees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at 888-581-8834 or 502-564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. KEHP does not collect or retain personal health or medical information through its wellness program; however, KEHP may receive aggregate information that does not identify any individual in order to design and offer health programs aimed at improving the health of KEHP members.
- If I have chosen one of the KEHP LivingWell plan options, I agree to fulfill the KEHP LivingWell Promise by completing (1) my online Humana*Vitality* Health Assessment; OR (2) a VitalityCheck (biometric screening). If I am choosing a LivingWell plan option during open enrollment, I will complete the Health Assessment OR a VitalityCheck (biometric screening) from January 1, 2016 through May 1, 2016. If I am a new employee and I choose a LivingWell plan option outside of open enrollment, I will complete the Health Assessment OR VitalityCheck (biometric screening) within 90 days of my coverage effective date.
- I have rights under HIPAA regarding the protection of my health information. KEHP will comply with the HIPAA Privacy and Security rules, and uses and disclosures of my protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP's Notice of Privacy Practices available at kehp.ky.gov.
- Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. I can be held responsible for any fraudulent act that I could have prevented while acting within my duties related to the KEHP, and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature on this application certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.
- Exceptions may apply to employees of certain employers participating in KEHP and to KTRS, KRS, LRP, and JRP retirees. Please refer to the participation rules of your employer or retirement system for further information.

PLEASE SUBMIT THIS APPLICATION TO YOUR COMPANY IC/HRG

Employee Signature	Date
Spouse Signature – *REQUIRED* if electing the cross-reference payment option	Date
IC/HRG Signature	Date
IC/HRG Printed Name	IC/HRG Phone Number
Spouse's IC/HRG Signature – *REQUIRED* if electing the cross-reference payment option	Date
Spouse's IC/HRG Printed Name	IC/HRG Phone Number